Date: ____________ Sex: M F Date of Birth: ______________ Marital Status: S M W D

Patient Information

Name: ______________________________ **Social Security #:** ____________

Address: ______________________________ **Drivers Licence#:** ____________

City: __________________ **State:** _____ **Zip:** ________ **Home Phone:** ____________

Who referred you? ____________________

Employer Information

Employer Name: ______________________________ **Work Phone:** ____________

Address: ______________________________ **Occupation:** ____________

City: __________________ **State:** _____ **Zip:** ________

Party responsible for account Information

Name: ______________________________ **Relationship to Patient:** ____________

Address: ______________________________ **Phone:** ____________

Employer's Name: ____________________ **Business Phone:** ____________

Dental Insurance Information

Primary Insurance Carrier: ____________________ **Insured party:** ____________

Policy #: ____________ **Group #:** ____________ **Agreement #:** ____________

Secondary Insurance Carrier: ____________________ **Insured party:** ____________

Policy #: ____________ **Group #:** ____________ **Agreement #:** ____________

Family Physician: ______________________ **Date of last exam:** ____________ **Phone:**

IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING, PLEASE CHECK "YES" OR "NO".

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	HEART PROBLEMS	☐	☐	ALCOHOLISM	☐	☐	FREQUENT HEADACHES	☐	☐	DO YOU HAVE ACHRONIC DISEASE?
☐	☐	HIGH BLOOD PRESSURE	☐	☐	ANEMIA	☐	☐	HEART MURMUR	☐	☐	ARE YOU UNDER A DOCTOR'S CARE
☐	☐	LOW BLOOD PRESSURE	☐	☐	ARTHRITIS	☐	☐	MALIGNANCIES	☐	☐	HERPES
☐	☐	CIRCULATORY PROBLEMS	☐	☐	ASTHMA	☐	☐	PSYCHIATRIC CARE	☐	☐	ARE YOU PREGNANT?
☐	☐	NERVOUS PROBLEMS	☐	☐	CONVULSIONS	☐	☐	RHEUMATIC FEVER			
☐	☐	RADIATION TREATMENTS	☐	☐	DIABETES	☐	☐	ARTIFICIAL JOINT			
☐	☐	EXCESSIVE BLEEDING	☐	☐	EPILEPSY	☐	☐	SINUS PROBLEMS			
☐	☐	ALLERGIES OR ADVERSE REACTIONS TO A DRUG	☐	☐	HEPATITIS	☐	☐	STROKE			
					DATE: ________	☐	☐	TUBERCULOSIS			
					IS YOUR DISEASE ACTIVE? Y N	☐	☐	RESPIRATORY PROBLEMS			
			☐	☐	DRUG ADDICTION	☐	☐	ULCER			
			☐	☐	JAUNDICE	☐	☐	VENEREAL DISEASE			
			☐	☐	DO YOU TAKE ASPIRIN DAILY?						

LOCAL ANESTHETIC, CODEINE, PENICILLIN, ASPIRIN, ETC.
EXPLAIN ____________________
____

OTHER MEDICAL PROBLEMS?
EXPLAIN ____________________
____
____

LIST PRESENT MEDICATIONS YOU TAKE ____________________
____
____
____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. PRESENT DENTAL PROBLEM ______________________________
2. WHEN WAS YOUR LAST DENTAL VISIT? ____________________ 3. WHAT WAS DONE?
____
4. ANY COMPLICATIONS WITH EXTRACTIONS? Y N EXPLAIN: ____________________
5. HOW OLD IS YOUR DENTURE OR PARTIAL? ____________
6. IF YOU COULD WISH FOR ANY CHANGE IN YOUR MOUTH, WHAT WOULD THAT BE? ____________________
____

YOUR SIGNATURE ______________________________ (PARENT OR GUARDIAN IF UNDER 16 YRS..) DATE: ____________

HEALTH HISTORY